SEYFARTH SHAW LLP ATTORNEYS

Health Care Reform Management Alert Series

Issue 12

Agencies Issue Guidance for External Review and Appeals Procedures

This supplements Issue 11 of our Health Care Reform Management Alert Series, which addressed the recently issued interim final regulations (IFRs) implementing the claims and appeals requirements of the Patient Protection and Affordable Care Act (PPACA). (Click here to access our general summary of health care reform and other issues in this series.)

As we stated in Issue 11, for plan or policy years beginning after September 23, 2010, the IFRs require that non-grandfathered group health plans and health insurance issuers provide updated internal claims/appeals processes and external review processes. While insured plans and group health plans not subject to ERISA will be required to follow state external review processes, self-insured ERISA plans (and insured and non-ERISA plans in states without adequate state processes) must apply a Federal external review process. The IFRs provided that the Departments of the Treasury, Labor, and Health & Human Services (the "Departments") would be issuing guidance in the near future on the Federal process.

[ ] Applies to grandfathered plans

[√] Applies to new health plans and plans that lose grandfathered status

As promised, on August 23, 2010, the Departments jointly issued guidance in the form of a notice (the "Notice") containing interim procedures for Federal external reviews of self-insured group health plans. Additional guidance on the permanent Federal review process is expected to be released by July 1, 2011. The Notice announces the availability of an enforcement safe harbor allowing plans to avoid excise tax liability and enforcement actions by the Department of Labor and Internal Revenue Service during this interim period. During this safe harbor period, a plan may either follow the external review procedures outlined in the Department of Labor's Technical Release No. 2010-01 (the "Technical Release") or voluntarily comply with state external review processes. Both options are discussed in more detail below.

The Notice also announces the availability of model notices for adverse benefit determinations, final internal adverse benefit determinations, and final external review decisions. These model notices may be used to satisfy the disclosure requirements for claims appeals under PPACA, and are available on the Department of Labor website at *http://www.dol.gov/ebsa/*. The Departments will soon release model language to describe internal and external appeals procedures in summary plan descriptions.

Technical Release External Review Procedures

The Technical Release sets forth standard and expedited external review procedures based on the *Uniform Health Carrier External Review Model Act* promulgated by the National Association of Insurance Commissioners.

Standard External Review

A group health plan must allow a claimant to file a request for an external review within four months of a claim denial. Within five days of receipt of such request, the plan must conduct a preliminary review determine if the claim is eligible for external

review. In order to be eligible, the claimant must have been covered under the plan at the time the service was requested or provided, the claim must not be a plan eligibility issue, the claimant must have exhausted the plan's required internal appeal process, and the claimant must have provided all information and documentation required to process external review. The plan must notify the claimant or the claimant's authorized representative within one day of completing preliminary review. If the request is incomplete, notification must describe the missing information. The claimant must then be allowed to perfect the claim request within 48 hours. If the request is incomplete and the plan is ineligible, the notification must describe the reasons for this decision.

If the claim is eligible for external review, the plan must assign an independent review organization (IRO) to conduct the review. The Notice does not specify a required timeframe for assigning an IRO after an eligibility determination.

Expedited External Review Procedures

A claimant may request expedited review at the time the claimant receives: (i) an adverse benefit determination if completing an expedited internal appeal would seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function; or (ii) a final internal adverse benefit determination if completing a standard external review would pose a similar risk, or if the final determination concerns an admission, availability of care, continued stay or health care item or service for which the claimant received emergency services and has not been discharged.

The plan must immediately determine whether the claim meets the external review requirements and notify the claimant of its determination. The Technical Notice does not define "immediately."

Contracts between plans and IROs must include the following provisions:

1. The IRO must use legal experts where appropriate to make coverage decisions under the plan.
2. The IRO will timely notify the claimant in writing of the requested claim's eligibility for external review and that the claimant may submit additional information within ten business days that the IRO will consider in making its decision.
3. The plan must provide the IRO documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination within five business days after the claim is assigned to the IRO. If the plan fails to provide such documents and information in a timely manner, the IRO may terminate external review and reverse the claim denial. The IRO must notify the claimant and the plan within one business day of such reversal.
4. The IRO must forward any additional information received from the claimant to the plan within one business day. The plan may then reconsider its claim denial in light of the new information. If the plan decides to reverse the claim denial, it must notify the claimant and IRO within one business day. Upon receipt of such notice, the IRO will terminate external review.
5. The IRO will review all information and documents timely received. The claim will be reviewed de novo. The IRO may consider the following additional information when making its decision:
    - the claimant's medical reports;
    - the health care provider's recommendations and reports;
    - the terms of the plan;
    - appropriate practice guidelines;
    - any applicable clinical review criteria used by the plan; and
    - the opinion of the IRO's clinical reviewer.
6. The IRO must provide written notice of its decision within 45 days. It is not clear whether this is measured in business days or calendar days.
7. The IRO's decision notice must contain the following information:
    - the date the IRO received the claim assignment;
    - references to evidence or documentation used in the decision;
    - a discussion of the principal reasons for the decision;
    - a statement that the decision is binding, except to the extent that other remedies may be available under Federal or state law;
    - a statement that judicial review may be available to the claimant; and
    - contact information for any applicable consumer assistance or ombudsman established under the Public Service Health Act.

If the plan determines that the claim request is eligible for external review, the plan must assign an IRO and forward necessary information and documentation electronically, by telephone, or by fax. The IRO will make a de novo decision and provide notice within 72 hours of the request for expedited external review. If notice of the decision is not in writing, it must be given within 48 hours.

Requirements for Contracts with IROs

A group health plan must contract with at least three accredited IROs. The requirements for IRO contracts under the Technical Release are explained in the above sidebar. The plan must randomly assign one of these IROs to review an eligible claim de novo. This means that the IRO can review new information and will not be bound by decisions reached during the plan's internal claims process. The IRO may not receive any financial incentives from the plan based on its likelihood of upholding the claim denial. If the IRO reverses the claim denial, the plan must immediately provide coverage or payment for the claim.

State External Review Processes

If a state with adequate external review procedures under PPACA chooses to expand these procedures to plans otherwise subject to the Federal procedures, a plan that voluntarily complies with such state procedures will satisfy the interim safe harbor. It is unclear from the Notice how to determine which state process applies. It is also unclear whether plans will have to comply with multiple state processes.

Employer Action Plan

- Determine if your plan is subject to the interim Federal external review procedures. If so, determine which safe harbor external review option is best for your plan.
- If the plan will follow the Technical Release procedures, research accredited IROs. Prepare to contract with at least three IROs using the contract requirements in the Technical Release.
- If your plan will follow state external review procedures and your plan covers employees in more than one state, determine which state process applies and whether compliance with more than one state process will be required.
- Contact your claims administrators to make sure that they are ready to comply with the new requirements.
- Watch for additional guidance related to model language for summary plan descriptions.

For further details, or if you have any questions regarding the new claims/appeals requirements, contact your Seyfarth Shaw LLP attorney or any Employee Benefit attorney listed on the website at www.seyfarth.com/employeebenefits, or send your questions to HealthReform@seyfarth.com.